Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 10, No.1 Spring 2002

Varicella Vaccine Shortage and Prioritization Recommendations

Currently, there is a nationwide shortage of varicella vaccine with delivery delays from Merck of up to 8 weeks. The manufacturer expects the shortage to continue into the late spring or early summer. While the shortage persists, there are some interim recommendations:

- **For children 12-18 months of age, the Advisory Committee on Immunization Practices recommends that providers delay varicella vaccination until 18 – 24 months of age.**
- All individuals whose varicella vaccination is delayed need to be placed on a recall list, and immunized as soon as vaccine is available.
- Susceptible, unvaccinated children may attend school or child care, if they have written documentation that they are on a recall list.
- Providers should only order a 1-month supply of vaccine at a time, but do not wait for previous orders to arrive before placing subsequent ones.

If varicella vaccine supplies are still not adequate, the ACIP recommends priority for vaccine for the following groups, in this order:

1. High risk children (HIV+, asthma, eczema), the family contacts of immunocompromised persons, health care workers, all other adolescents and adults;
2. Children 5-12 years, prioritizing those attending kindergarten – 3rd grade and 7th –10th grades;
3. Children 2-4 years old, prioritizing those attending child care centers and preschool.

Please remember that all individuals whose vaccination is delayed must be placed on a recall list. Thank you for your cooperation during this difficult period. If you have any questions, please call the MDPH Immunization Program at 617-983-6800 or 888-658-2850.

Anthrax, Airborne Infection, MDPH, and the Passing of Richard L. Riley

Airborne infection as a vehicle of bioterrorism has been in the news of late. It is little appreciated that our current understanding of airborne infection is remarkably recent and that the Massachusetts Department of Public Health played an important role in the story. This article is prompted by the December 17, 2001 death of Dr. Richard L. Riley, a pioneer in the field.

In the early 1930's, the Massachusetts Department of Public Health was concerned that the stagnant water aerosolized to keep dust down in textile mills might be a source of bacterial infection among workers. A sanitary engineer at Harvard University, William Firth Wells, had developed an air centrifuge to sample air for bacteria, and was commissioned by MDPH to investigate mills. Riley was a Harvard medical student at the time, working with Wells on this project. Wells and Riley cultured bacteria from the air, but more importantly went on to speculate that these airborne particles, called droplet nuclei, might also be the vehicles for person to person airborne contagion of respiratory infections as measles and tuberculosis. Riley co-authored the scientific papers on the textile mill investigation and on the droplet nuclei theory (On Airborne Infection, Study II. Droplets and Droplet Nuclei. Wells, Riley, et. al. Am J Hygiene, 1934:20. 611-18), the first of more than a hundred scientific papers he would go on to write on airborne infection, and also on lung physiology, an area in which he would become equally famous. He became Chairman of the

continued on page seven

Inside

Lyme Vaccine Off the Market

LYMErix ®, a vaccine for Lyme disease developed by GlaxoSmithKline Pharmaceuticals, was removed from the market on February 25, 2002. The manufacturer stated that sales of the vaccine were not meeting sufficient levels to make the product sustainable. The vaccine was approved for use in persons aged 15-70 years by the Food and Drug Administration (FDA) in December, 1998.

Epidemiology

Hepatitis A Outbreak in Bristol County

In November 2001, the Massachusetts Department of Public Health (MDPH) Division of Epidemiology and Immunization and local health departments investigated an outbreak of hepatitis A in Bristol County after report of seven laboratory-confirmed cases. Extensive case finding identified an additional 46 cases. A case-control study implicated a Swansea restaurant as the location where at least 35 cases may have been exposed. In October 2001, a foodhandler at this establishment had hepatitis A, but transmission risk was thought to be low because bare hand contact with ready-to-eat foods was not reported.

Two cases confirmed in November were foodhandlers at a second food establishment in Swansea. Since both had worked during their infectious period handling ready-to-eat foods, immune globulin (IG) was recommended for patrons who may have been exposed. Over 1600 doses of IG were administered during a 2-day clinic sponsored by Southcoast Health System with assistance from school nurses and surrounding health department and health care facility personnel. IG can prevent hepatitis A if given within 2 weeks of exposure.

In 2001, 347 cases of hepatitis A were reported to MDPH, a significant increase over the average of 183 cases/year reported between 1995 and 2000. Increased case rates occurred in Dukes, Nantucket, and Suffolk counties. Similar increases in incidence were observed in Connecticut and Rhode Island.

The incubation period for hepatitis A is 15-50 days, with an average of 28-30 days. Cases are considered infectious for three weeks, because the virus can be shed in the stool from two weeks prior to symptom onset until one week after symptom onset. Infected foodhandlers need to be carefully interviewed to determine whether their food handling procedures and practices provide a possible risk of transmission. Interviews should be done in a timely manner and include questions about dates worked during the foodhandler's infectious period, job duties, foods prepared during the infectious period (i.e. ready-to-eat foods), whether or not the case had diarrhea, and whether gloves or other barrier protection were used consistently.

Analysis of the outbreak is ongoing and the final report is expected in the first quarter of 2002. For more information about Hepatitis A transmission, go to http://www.state.ma.us/dph/cdc/factsheets/fshepa.pdf .

West Nile Virus Update

National surveillance data for the year 2001 indicate a dramatic expansion of West Nile virus (WNV) activity to 27 states and Washington, D.C. As of November 20, 2001, 53 human cases (four deaths) were attributable to WNV. Three of these cases, including one death, occurred in Massachusetts. In addition, an outbreak of WNV fever occurred in horses in southeastern Massachusetts with 37 laboratory-confirmed cases, among which five horses died of the disease or were euthanized. WNV was also confirmed in 1104 birds and in 25 mosquito pools throughout eastern Massachusetts. One human case of eastern equine encephalitis (EEE) was also confirmed.

While most dead birds will not be collected and tested for WNV in Massachusetts in 2002, tracking their locations will play an integral role in directing surveillance and control efforts. This year, local health officials and the public should report dead birds to the MDPH WNV Information line at **1-866-MASS-WNV (627-7968)**. MDPH staff will notify the caller if the bird is to be tested and coordinate with local health officials to arrange for its safe collection and transport to the State Laboratory Institute (SLI).

Fixed mosquito trap sites will be located in communities that had high WNV activity in 2001. In addition, mosquitoes collected from long-term fixed trap sites in the EEE high-risk areas will be tested for both EEE virus and WNV. MDPH will also increase mosquito collection in areas that demonstrate high dead bird density.

MDPH will inform medical providers about mosquito-borne diseases and will regularly remind them to report suspect cases of encephalitis, meningo-encephalitis and meningitis of unknown etiology, and to submit specimens to the SLI for appropriate testing. In areas of Massachusetts with increased WNV activity, hospital emergency departments will be contacted weekly and case follow-up coordinated with hospital infection control practitioners. Health care providers may report suspect cases to the Division of Epidemiology and Immunization at (617) 983-6800 or through the WNV Information line.

MDPH will post surveillance data to the MDPH web site at www.state.ma.us/dph/. This site will contain data maps, educational materials, the 2002 WNV Surveillance and Control Plan, and detailed information on ways to limit exposure to mosquitoes. Official press releases, local community information and information for providers will be available. Throughout the season, the WNV Information Line will provide access to general WNV information, personal protection recommendations and information on pesticides.

Pneumococcal Conjugate Vaccine (PCV7) Shortage – A Revised Schedule is Recommended

A national PCV7 shortage is expected to continue through the 2nd quarter of 2002. The Advisory Committee on Immunization Practices (ACIP) has issued interim recommendations for a revised schedule for PCV7 until adequate supplies are available (CDC. MMWR. 2001;50:1140-42.) The three key principles that underlie the recommendations are:

1. Providers should decrease the number of doses given to healthy infants, rather than leaving some children completely unprotected.
2. Reductions in PCV7 use need to be made by all providers regardless of the current supply in your office.
3. Providers should reduce the size of their vaccine orders so that available vaccine can be distributed as widely as possible.

Until adequate supplies of PCV7 vaccine are available, the ACIP recommends the following:

1. **The highest risk children < 5 years of age should continue to be vaccinated with a full series of PCV7.** The highest risk groups include children with sickle cell disease and other hemoglobinopathies, anatomic asplenia, chronic disease (including chronic cardiac or pulmonary disease and diabetes mellitus), CSF leak, HIV infection, immunocompromising conditions, immunosuppressive chemotherapy or long-term systemic corticosteroids use, and those who have received a solid organ transplant.

2. **Healthy infants and children, without other risk factors, < 24 months old should receive a decreased number of doses.** The decreased schedule in this age group depends on local vaccine supply and the age at first dose. In Massachusetts, we currently are experiencing a moderate shortage. For children < 6 months of age, PCV7 should be given on a 2, 4 and 6 month schedule and **the 4th dose should be deferred** in all healthy children, without other risk factors, as outlined in the table below. The schedule for children receiving their 1st dose at > 6 months of age is also outlined in the table.

3. **Defer PCV7 for healthy children without risk factors who are 24 – 59 months of age.**

4. **Maintain lists for recall.** Providers should maintain a list of children who need to be recalled to receive additional doses of PCV7. Infants who have only received 2 doses should be prioritized for recall. Those who have received 3 doses and are eligible for their 4th dose would be a second priority group.

5. **Pneumococcal polysaccharide vaccine (PPV23) should not be used in children < 24 months of age.**

Interim PCV7 Schedule During the Vaccine Shortage

Shortage Status	Massachusetts & Other States Experiencing a *Moderate* Shortage
Age of First PCV7 Vaccination	*Schedule*
< 6 months	2, 4 and 6 months (defer 4th dose)
7 - 11 months	2 doses given 2 months apart; plus a 12 - 15 month dose
12 - 23 months	2 doses given 2 months apart
≥ 24 months	No PCV7 vaccination

Vaccine Ordering

The Massachusetts Department of Public Health is asking all providers to implement these new recommendations and reduce their PCV7 orders by 25%. In addition, please order only a 1-month supply at a time.

DTaP, Td, and MMR Vaccine Availability Updates

Unlike other parts of the country, Massachusetts is currently not experiencing Td or MMR vaccine shortages, and providers should continue to administer these vaccines according to the usual schedules. However, inventories of DTaP vaccine are limited, both nationwide and in Massachusetts. Providers should continue to administer DTaP vaccine according to the usual schedule. If fewer doses become available, the MIP may have to issue interium guidelines for prioritization.

If you have any questions, please call the MDPH Immunization Program at 617-983-6800 or 888-658-2850.

Pneumococcal Vaccine (PPV23) Available Free for Adults at Risk

Pneumococcal disease kills 15,000 Americans every year. Despite the availability of free state-supplied PPV23, an estimated 300,000 Massachusetts residents 65 years of age or older have never received pneumococcal vaccine. Even worse, 64% of Massachusetts residents 18 – 64 years of age with a medical condition that puts them at risk for pneumococcal disease have never received the vaccine. Most people need only one dose of PPV23. For more information, call your Regional MDPH Office or the MDPH Vaccine Management Unit at (617) 983-6828.

STD

College and University Health Center Survey Assessment

The Division of Sexually Transmitted Disease Prevention, MA Department of Public Health (MDPH), surveyed colleges and universities in Massachusetts to assess the extent of clinical and prevention/education services for sexually transmitted diseases (STD) in the spring of 2001. Sixty-seven of 89 institutions responded (14 state, 42 private and 11 community colleges).

Most respondents (91%) had a student health center on campus. Of these, 86% (53/61) offered services related to STDs. These services included diagnostic testing (83%), screening based on risk in the absence of symptoms (75%), one-on-one counseling for STDs, including HIV (94%), and STD treatment (74%). Most health centers indicated access to laboratory testing, either on-site or elsewhere. These services were most commonly available for chlamydia infection, herpes and gonorrhea. In contrast, ability to test for HIV antibodies was less available (47% of respondents). Health centers indicated that STD testing was performed primarily upon request by the student (87%).

The survey revealed that STD clinical services are available on most campuses. When services are not provided, students are referred to local physicians, health centers and STD clinics. However, other services relating to STD prevention were less available. Most schools rely exclusively on urging students to notify partners of possible exposure to an STD (up to 89%, depending on the STD). The highest reported rates for use of health department partner notification were for syphilis (30% of respondents) and gonorrhea (26% of respondents). In addition, most respondents stated that they do not report STDs to the Department of Public Health (65%).

Respondents to questions regarding prevention services (n=55) indicated a variety of educational activities related to STD. These included brochures (96%), one-on-one counseling in the health center (92%), posters (87%), health fairs (81%), lectures (75%), peer education (64%), messages in student newsletters (54%), orientation presentations (50%), information included within orientation packages (32%), and on web pages (32%). In addition, 96% of the student health centers provided free condoms.

Less than one-half (44%) of schools indicated they had a working relationship with their local health department or with a community organization. When asked how the Department of Public Health might assist schools change, expand or improve services, 90% (55/61) indicated a desire for more educational materials for students. Almost three quarters (72%) requested educational materials for staff, 64% asked for in-service education for the staff, and 54% asked for diagnostic and screening laboratory services. For more information, contact the MDPH Division of STD Prevention at (617) 983-6940.

Syphilis in Massachusetts 2001

In 2001, there were 107 cases of infectious syphilis reported in Massachusetts. This was a 23% decrease compared to 2000 (139 cases) and is only 10 more cases than the historic low of 97 cases reported in 1999. Even though there was a decrease in reported infectious syphilis cases, there was an increase in syphilis among men who have sex with men (MSM). Reported syphilis among MSM accounted for 25% of cases in 2000 and 49% of cases in 2001.

Sexual encounters arranged through the Internet contributed to the increase in syphilis among MSM. Additional risk factors identified included attendance at a bathhouse in Providence, R.I. and travel to other cities in the US. Health departments in San Francisco and New York collaborated on follow-up of contacts.

In the second half of 2001, an outbreak of infectious syphilis linked to Provincetown occurred. As of February 2002, there have been 13 cases. All were men who have sex with men. Meetings were held with the clinical and other staff at the Outer Cape Health Center in Provincetown to review appropriate screening and diagnostic work, assure communication, and develop prevention messages. Serology kits for syphilis testing were provided for case contacts who were unable to pay for the serologic tests. Staff of the Provincetown AIDS Support Group and the VNA of Cape Cod are providing outreach education and screening services. We are exploring further collaboration to promote prevention activities. Contact the MDPH Divsion of STD Prevention at (617) 983-6940 for more information.

Bioterrorism Perspective

The risk of infection with *Bacillus anthracis* remains low despite intense media coverage over the last several months. The public's sense of vulnerability to agents of bioterrorism reached an unprecedented high. In the weeks since October 4, 2001, the day the first anthrax case was reported in Florida, the MDPH has worked to alleviate fear and disseminate information. Measures have included increased 24-hour coverage by epidemiology and laboratory staff, more extensive on-line information, a new telephone hotline, communication to clinical providers regarding anthrax, and syndromic surveillance systems to provide early warnings of unusual disease occurrences. Over 3000 environmental specimens have been tested for anthrax in Massachusetts, and none have been positive.

Exposure to anthrax-contaminated mail is the only clear risk factor that has been identified so far for recent anthrax

continued on page five

You Be The Epi

You are the health agent in a Massachusetts town. Upon arriving at work one morning, you receive a phone call from the school nurse at the high school. She is asking for your advice about a suspicious white powder found on a desk in the school library. What should you do?

Your first step is to help assess the level of risk. While you do this, remain calm, and urge the nurse to remain calm. Remind her that there have been no cases of anthrax in Massachusetts. Of the more than 3,000+ environmental samples submitted to the State Laboratory Institute (SLI) for testing since October 2001, none have tested positive. It is very unlikely that this powder will test positive.

Assist the nurse in gathering and organizing information. What does the substance look like? Where was it found? Is there a common sense explanation? Might a janitor have spilled a cleaning agent, or a student spilled some food? Most importantly, is there any evidence of an expressed threat? Write down any information you get from the nurse, including a list of all those present at the scene and those who had contact with the powder.

Decide whether a 911 call should be made. If you or the school nurse have sufficient reason to believe that this powder represents a threat, **call 911**. Further management of the situation becomes a matter for law enforcement and the local fire department or HazMat (Hazardous Materials Response) team. The responding agency, which may be police, fire, or HazMat, will collect the sample and transport it to the SLI. Anyone who has touched the powder should wash their hands and any exposed skin thoroughly with soap and water. If the powder spilled onto clothes, there may be a need to collect and safely bag the soiled clothing. (Note: If you decide not to call 911, exposed skin should still be washed, and the desk may be cleaned appropriately.)

Provide reassurance to the public.

- People should be urged to be calm and be reminded that exposure to anthrax does not present an immediate threat of injury.
- Even if this specimen does test positive - a very unlikely event - anthrax is treatable with antibiotics.
- Results of anthrax tests on samples sent to the SLI are usually available 48 hours after the specimen is received. Prophylactic treatment with antibiotics is not recommended unless the sample tests positive, except in very high-risk circumstances. Medical providers, together with epidemiologists from the MDPH, can help make this determination.
- Remember, samples such as the one found in the school are considered low risk unless they were delivered by US or courier mail AND contained a threat.

Shortly after you finish speaking with the school nurse, calls begin coming in from reporters and concerned parents asking if the high school is going to be evacuated. What is your recommendation?

The decision to evacuate or quarantine a public building requires credible, or at least potential, evidence of a threat. In the case of a suspicious powder on a desk with no threat, evacuation is normally not recommended. However, a school principal, superintendent, or fire chief should make this decision in consultation with the local health agency and law enforcement officials.

Handling calls from the press can be the most stressful part of a local health officer's job and you should plan ahead. If your local community does not already have a designated press or public relations spokesperson for emergencies, you may want to consult with municipal police, fire and school officials as to who will serve as point person for press inquiries. If the school is evacuated, the local health department usually decides when to re-open it.

Risk assessment in these circumstances requires a balance between common sense and the need to take threats seriously. On the one hand, it would be a misuse of resources to test every white powder found across the Commonwealth, or every piece of mail that arrives with an unfamiliar return address. On the other hand, an increased index of suspicion is prudent. Risk assessment and response in these situations are areas of evolving development.

If the powder did test positive for anthrax, those at risk would need to be identified, contacted, treated and this would be performed in the context of a federal investigation and the national media spotlight.

The MDPH Division of Epidemiology and Immunization maintains an on-call system with trained epidemiologists available 24 hours a day at (617) 983- 6800 to provide consultation and assistance.

Bioterrorism Perspective continued from page four...

cases. MDPH has established guidelines, available at http://www.state.ma.us/dph/topics/bioterrorism/screenguide.pdf, to assist with assessing risk of exposure to an unknown powder. Suspicious materials will continue to be tested by the MDPH; however, submitters are encouraged to assess the level of risk by using the categories described in the guidelines. Epidemiologists can be reached by calling 617-983-6800 to discuss exposure situations and to assist in determining level of risk.

Refugee and Immigrant Health

African Refugees in Massachusetts

Refugee admissions from countries in Africa have increased significantly in recent years as the federal ceiling for this region has risen from 7,000 in 1997 to 22,000 in 2002. While admissions are consistently below this ceiling, the increase in proportion of all admissions, actual number, and diversity of African refugees are dramatic.

During the fifteen-year period 1986-2001, over 3,100 refugees from 23 countries in Africa resettled in Massachusetts. Most have come since 1992. Somalis represented the second significant wave of African refugee arrivals, following Ethiopians in the 1980's.

Many Somalis came to Massachusetts after spending years in refugee camps in Kenya. To increase access to public health services for these newcomers, the Refugee and Immigrant Health Program hired bilingual, bicultural community members to serve as outreach educators. The outreach educators have been key in linking the two very different cultures: that of the new arrival and that of the US health care system. Over time, staff have embraced two educational approaches. Home visits or group meetings to welcome and orient new arrivals have served to reduce the anxiety of resettlement and provide resources and education on accessing health care and understanding health issues. Workshops on cultural competency are conducted for health and social service providers. Very often, providers have been unfamiliar with the diversity and geography of Africa, as well as health beliefs, religious backgrounds and cultural practices.

In 2001, 84% of Africans arriving in Massachusetts were from Sudan (the largest national group), Somalia or Liberia, with lesser numbers from Sierra Leone, Ethiopia, and Congo. Applying the same approach as that taken with Somalis, bilingual, bicultural staff work to meet the needs of these newer communities. For some arrivals, such as those from Rwanda and Burundi, we are only able to meet their linguistic needs with staff who speak their second or third language, French. In other cases, we employ several staff persons to accommodate the diverse linguistic needs of a national group, for example, for Sudanese refugees, among whom numerous languages are spoken.

Refugee Admissions Update

Resettlement of refugees in the US, which was effectively shut down after September 11th, has slowly resumed, with new security measures in place. From October 2001 through January 2002, fewer than 3,000 refugees were admitted to the US, compared with over 16,000 during the same period last year. Among those waiting to enter the US are some 22,000 persons who have been approved as US refugees. Many wait in crowded refugee camps abroad.

The U.S. agencies responsible for admissions – the State Department and the Immigration and Naturalization Service – have pledged to come as close as possible to reaching the ceiling of 70,000 refugee admissions this year. In Massachusetts, as across the country, many who believe strongly in the refugee program and the role the US plays in assuring a future for refugees, are actively working to revitalize the US Refugee Resettlement Program.

African Refugee Community Health Initiative

In July 2001, the Refugee and Immigrant Health Program received funding from the federal Office of Refugee Resettlement to begin an African Refugee Community Health Initiative. Four African community agencies are funded through the initiative – African Initiative for Community Development, Somali Development Center, Somali Women and Children's Association, and Universal Human Rights International. These agencies have initiated projects that complement both the activities of the Refugee and Immigrant Health Program bilingual, bicultural community outreach educators and the BASICS program of the Massachusetts Office for Refugees and Immigrants.

The central goal of the health initiative is engaging newly arrived African refugees in community health education and dialogue. A variety of health topics will be addressed in a manner that responds to the experiences, cultures and languages of refugees from Africa. In this way, refugees can make more informed decisions about how and when to incorporate new health behaviors into their lives. Drawing on the experiences and voices of refugees, agency staff will also develop and offer health care provider workshops to increase their capacity to deliver responsive, appropriate care.

Time to Think About the 2002-03 Flu Season

As in previous years, state-supplied flu vaccine will not be sufficient to meet the demand for flu vaccine in Massachusetts. Health care providers should begin planning now for the next flu season by placing their orders for privately purchased vaccine as early as possible. The sooner the orders are placed, the better the price is likely to be.

To supplement the state-supplied flu vaccine they receive, cities and towns can purchase additional flu vaccine at the state-contracted price of $5.90/dose. This privately-purchased vaccine can be used at the discretion of the city or town, including to immunize municipal employees, but should not be distributed or sold. If you have not received information on how to order flu vaccine at the state-contracted price, call the MDPH Vaccine Management Unit at 617-983-6828.

Richard Riley continued from page one.....

Department of Environmental Health Sciences, Johns Hopkins University, and retired to Petersham, Mass. in 1977. Stimulated by tuberculosis outbreaks at a Chelsea office building and a Boston homeless shelter in the early 80's, Riley was contacted to help in planning and studying the use of ultraviolet germicidal light to prevent tuberculosis transmission – work continued until his death at age 90.

Prior to 1935, contact, including direct droplet spread, was considered the only route of contagion. This dogma was championed by the highly regarded health officer of Providence, Rhode Island, Charles Chapin, who wrote in his influential 1910 monograph: **"Sources and Modes of Infection"**

> "Bacteriology teaches that former ideas in regard to the manner in which diseases may be airborne are entirely erroneous; that most diseases are not likely to be dust-borne, and they are spray-borne for only 2 or3 feet,a phenomenon which after all resembles contact infection more than it does aerial infection as ordinarily understood"

In 1935, Wells challenged Chapin, arguing that measles was airborne and could be controlled with upper room ultraviolet irradiation. He demonstrated the efficacy of germicidal ultraviolet air disinfection in a field trial in day schools outside of Philadelphia where measles transmission was reduced. Still, in a 1946 official report, the American Public Health Association stated: "Conclusive evidence is not available at present that the airborne mode of transmission is predominant for any particular disease". This evidence was provided for tuberculosis by a definitive experiment designed by Wells near the end of his life, and carried out by Riley at the Baltimore Veterans Administration Hospital from 1958-1962. A 6-bed experimental tuberculosis ward was reconfigured so that the exhaust air was delivered to a penthouse where it was breathed by 150 guinea pigs in a special exposure chamber. The guinea pigs were skin tested for TB infection each month. The lungs of infected animals showed a single peripheral focus of tuberculosis, the result of inhaling a single infectious droplet nucleus. Since the only connection between the patients and the guinea pigs was air, the reality of airborne infection was established for tuberculosis. To be certain that all of the infection reached the guinea pigs through contaminated air from the ward, ultraviolet light was used in the ventilation ducts and this completely halted transmission.

Just the week before Riley's death, Dr. Edward Nardell, the state TB Control Officer at that time, for whom Dr. Riley was a friend, colleague and mentor, attended a meeting at CDC to plan the re-establishment of a Wells-Riley ward in a hospital in South Africa. In 2002, there is still no other way to quantitatively sample air for tuberculosis. The first goals of the new study will be to determine how long patients with multidrug-resistant TB remain infectious on therapy, and to evaluate the use of germicidal ultraviolet irradiation in developing countries.

In February of 2002, Dr. Edward Nardell left his position as state TB Control Officer after 18 years, to devote more time to international tuberculosis control in the Department of Social Medicine, Harvard Medical School and with Partners in Health. Dr. Nardell will be missed by the Department of Public Health, but will continue as a close colleague and valuable resource in the struggle against tuberculosis.

Southeast Regional TB Clinical Services Highlight

Southeast Tuberculosis Surveillance Area (TSA) 5
TSA Nurse: Joan Thompson-Allen, R.N., B.S.
Administrative Assistant: Kelly Letendre

In 2001, there were 41 verified cases of tuberculosis in the southeast region. The higher risk communities include Brockton, Quincy, and New Bedford. Six TB clinics are located in this region. This update will focus on the Brockton TB Clinic. This clinic does an excellent job of providing services to the diverse population in the greater Brockton area.

The Brockton TB Clinic moved from the outpatient department of Brockton Hospital to the white house in the front of the hospital. The new facility provides more space for patients and staff. Dr. William Stenson, and Dr. Devi Vedula provide medical services at the clinic. Stephanie Morin is the TB clinic manager, Donna Kenn is the administrator/coordinator, and Peg Doneghey provides secretarial services. Eddy Bien Aime and Leandro Fortes, outreach staff with the TB Division, translate and provide education and follow up for Haitian and Portuguese-speaking patients. Helen Singh coordinates TB services between the medical clinic and the Brockton Health Department and community.

TB Clinics are held weekly on Tuesdays from 9 am to 4 pm. Physician appointments are held in the morning and nurse visits are in the afternoon. The clinic is on the public transportation bus line. Visits are scheduled by appointment only.

Save the Dates for the Division of Tuberculosis Prevention and Control

Southeast Regional TB Conference

The conference will be held at the Heritage State Park Visitors Center on Thursday May 30th, 2002. Please contact Kelly Letendre in the southeast regional TB office at (508) 947-1231 for more information.

CD UPDATE
Room 557
State Laboratory Institute
305 South Street
Boston, MA 02130

Bulk Rate
US Postage
PAID
Boston, MA
Permit No.
#55970

Return Service Requested

Save The Dates

7th Annual MIAP Skills Building Conference

Worcester Holiday Inn, Worcester, MA. Thursday, May 16, 2002 from 8:00 am - 4:30 pm. For more information contact MIAP at (978) 524-0561, ext. 235 Fax: (978) 524-0913

6th Annual Public Health Nursing Conference

Anna Maria College, Paxton, MA. Wednesday, June 12, 2002 from 8:30 am - 4:00 pm. Sponsored by the Massachusetts Association of Public Health Nurses, Massachusetts Department of Public Health, Massachusetts Public Health Association. Contact (617) 524-6696 x104 for more information or to register.

Immunization Update 2002 Workshops

For dates, times and locations, contact your regional immunization office or the MDPH Vaccine Management Unit at (617) 983-6828.

Epidemiology and Prevention of Vaccine Preventable Diseases satellite course that was scheduled to begin in February has been canceled due to pressing work related to Smallpox activities. While we recognize this is one of our most popular NIP events, we appreciate your understanding as we shift resources to meet emerging needs. It will be offered again in 2003.

The 2002 NIP Satellite Course schedule is as follows:

June 27: Immunization Nursing Issues (New and 1st program in 2002!!!)
August 15: Immunization Update 2002
December 5: Surveillance of Vaccine-Preventable Diseases

Contact Walt Lasota at (617) 983-6834 for satellite course registration information.

COMMUNICABLE DISEASE UPDATE is a free quarterly publication of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health.

Howard K. Koh, MD, MPH, Commissioner of Public Health

To subscribe, please call or email Jacqueline Dooley at (617) 983-6559 or jacqueline.dooley@state.ma.us

Bureau of Communicable Disease Control
Alfred DeMaria, Jr., MD, Assistant Commissioner
(617) 983-6550

HIV/AIDS Surveillance Program
James Murphy, MPH, Director
(617) 983-6560

Division of Epidemiology and Immunization
Robert S. Goldstein, MPH, Director
Susan Lett, MD, MPH, Immunization Medical Director
Bela Matyas, MD, MPH, Epidemiology Medical Director
(617) 983-6800

Division of STD Prevention
Paul Etkind, DrPH, MPH, Director
(617) 983-6940

Refugee and Immigrant Health Program
Jennifer Cochran, MPH, Director
(617) 983-6590

Division of TB Prevention and Control
Sue Etkind, RN, MS, Director
(617) 983-6970

Managing Editor
Jacqueline Dooley
(617) 983-6559

Contributing Editors - Elizabeth Sheehy, Marilyn DelValle, Kathleen Hursen, RN, MS and Rachel Heckscher, MPH